

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	6,171	87	5,308	11,566	8	
9	SNF/PED					9	
10	ICF	28,636	1,043	1,102	30,781	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	34,807	1,130	6,410	42,347	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.35%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 30 and days of care provided 2,534

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/09 Ending: 12/31/09

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	227,289	20,675	3,364	251,328		251,328		251,328		1
2	Food Purchase		240,453		240,453		240,453	(8,222)	232,231		2
3	Housekeeping	149,619	89,073		238,692		238,692	250	238,942		3
4	Laundry	95,533	10,850		106,383		106,383		106,383		4
5	Heat and Other Utilities			150,092	150,092		150,092	1,456	151,548		5
6	Maintenance	45,427	69,388	11,917	126,732		126,732	724	127,456		6
7	Other (specify):*										7
8	TOTAL General Services	517,868	430,439	165,373	1,113,680		1,113,680	(5,792)	1,107,888		8
	B. Health Care and Programs										
9	Medical Director			3,250	3,250		3,250		3,250		9
10	Nursing and Medical Records	1,823,173	59,810	11,797	1,894,780		1,894,780	2,155	1,896,935		10
10a	Therapy			350,874	350,874		350,874		350,874		10a
11	Activities	67,359	9,268	120	76,747		76,747		76,747		11
12	Social Services	47,175			47,175		47,175		47,175		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,937,707	69,078	366,041	2,372,826		2,372,826	2,155	2,374,981		16
	C. General Administration										
17	Administrative	211,770		122,094	333,864		333,864	(74,294)	259,570		17
18	Directors Fees										18
19	Professional Services			39,680	39,680		39,680	26,292	65,972		19
20	Dues, Fees, Subscriptions & Promotions			18,947	18,947		18,947	2,535	21,482		20
21	Clerical & General Office Expenses	354,211		44,884	399,095		399,095	40,406	439,501		21
22	Employee Benefits & Payroll Taxes			340,133	340,133		340,133	4,894	345,027		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,352	1,352		1,352	15	1,367		24
25	Other Admin. Staff Transportation			8,475	8,475		8,475	1,224	9,699		25
26	Insurance-Prop.Liab.Malpractice			113,799	113,799		113,799	3,891	117,690		26
27	Other (specify):* Mgmt Alloc of Benefi							15,231	15,231		27
28	TOTAL General Administration	565,981		689,364	1,255,345		1,255,345	20,194	1,275,539		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,021,556	499,517	1,220,778	4,741,851		4,741,851	16,557	4,758,408		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center #0039636 Report Period Beginning: 01/01/09 Ending: 12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			95,307	95,307		95,307	34,527	129,834			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,402	15,402		15,402	221,458	236,860			32
33	Real Estate Taxes							96,769	96,769			33
34	Rent-Facility & Grounds			560,000	560,000		560,000	(560,000)				34
35	Rent-Equipment & Vehicles							1,045	1,045			35
36	Other (specify):* Mortgage Insurance							18,321	18,321			36
37	TOTAL Ownership			670,709	670,709		670,709	(187,880)	482,829			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,309		177,309		177,309		177,309			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Non-allowable cost			28,688	28,688		28,688	(28,688)				43
44	TOTAL Special Cost Centers		177,309	110,813	288,122		288,122	(28,688)	259,434			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,021,556	676,826	2,002,300	5,700,682		5,700,682	(200,011)	5,500,671			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/09

Ending:

12/31/09

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(55,567)	30		9
10	Interest and Other Investment Income	(15,248)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(283)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(48)	43		18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	44	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,977)	43		24
25	Fund Raising, Advertising and Promotional	(198)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(994)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(11,962)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (94,633)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(105,378)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (105,378)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (200,011)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center

ID# 0039636

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Chamber of Commerce Dues	\$ (100)	20	1
2	Lab Expense Med A	(9,038)	43	2
3	X Ray Expense Med A	(7,750)	43	3
4	Real Estate Tax	4,926	33	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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27				27
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29				29
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,962)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule 6A		See Schedule 6B		See Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Services	\$	Cahokia Building LLC	100.00%	\$ 22,138	\$ 22,138	1
2	V	20 Dues Fees Subscriptions		Cahokia Building LLC	100.00%	2,500	2,500	2
3	V	26 Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	3,392	3,392	3
4	V	30 Depreciation		Cahokia Building LLC	100.00%	87,539	87,539	4
5	V	32 Interest Income	154	Cahokia Building LLC	100.00%		(154)	5
6	V	32 Interest		Cahokia Building LLC	100.00%	232,548	232,548	6
7	V	33 Real Estate Tax		Cahokia Building LLC	100.00%	88,334	88,334	7
8	V	34 Rent	560,000	Cahokia Building LLC	100.00%		(560,000)	8
9	V	36 Mortgage Insurance		Cahokia Building LLC	100.00%	18,321	18,321	9
10	V	32 Amortization		Cahokia Building LLC	100.00%	4,312	4,312	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 560,154			\$ 459,084	\$ * (101,070)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Cahokia Nursing and Rehabilitation Center, Inc.
0039636
12/31/2009

VII Related Parties - Page 6

Schedule 6A

Share Number	Shareholder Name	Beginning Shares	Ownership Percentage
1	Abraham J Stern	70	4.67
2	Albert Milstein	395	26.33
3	Sheldon Wolfe	355	23.67
4	Ronnie Klein as Trustee	75	4.99
5	Maurice Aaron	70.1	4.67
6	Michael Klein Revocable Trust	30	1.99
7	Wanda Bowling	10	0.67
8	Miriam Y Klein as Trustee	100	6.67
9	Michael A Klein as Trustee	100	6.67
10	Kenneth Klein	75	4.99
11	Susan Stern	70	4.67
12	Jonathan B Stern 2001 Trust	23.33	1.56
13	Todd A. Stern 2001 Trust	23.33	1.56
14	Evan M. Stern	23.33	1.56
15	Moshe Herman	10	0.67
16	Ora Aaron	70	4.67

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

Beauvais Manor Healthcare and Rehab	St. Louis, Mo
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 15	\$	15
16	V	3 Housekeeping		SW Management Co.	100.00%	250		250
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,456		1,456
18	V	6 Maintenance		SW Management Co.	100.00%	724		724
19	V	17 Administrative	122,094	SW Management Co.	100.00%	47,800		(74,294)
20	V	19 Professional Services		SW Management Co.	100.00%	4,110		4,110
21	V	20 Dues,Fees,Subs & Promotions		SW Management Co.	100.00%	135		135
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	40,406		40,406
23	V	24 Travel and Seminar		SW Management Co.	100.00%	15		15
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	1,224		1,224
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	499		499
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	15,231		15,231
27	V	30 Depreciation		SW Management Co.	100.00%	2,555		2,555
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,509		3,509
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,045		1,045
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 122,094			\$ 118,974	\$ *	(3,120)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Food	\$ 11,345	S & E Medical Supply Co.	100.00%	\$ 8,002	\$ (3,343)	15
16	V	3 Housekeeping	320	S & E Medical Supply Co.	100.00%	320		16
17	V	10 Medical Supplies	944	S & E Medical Supply Co.	100.00%	3,099	2,155	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 12,609			\$ 11,421	\$ * (1,188)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.50	Salary	\$ 14,340	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	5	10.00	Salary&Fees	19,120	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	7.50	Salary	14,340	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9		All individuals work in excess of 40 hours per week.									9
10											10
11											11
12											12
13								TOTAL	\$ 47,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization SW Management Co.
 Street Address 7434 N. Skokie Blvd
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	657,730	11	\$ 177	\$ 54,750	\$ 15	1	
2	3	Housekeeping	Bed Days Available	657,730	11	3,004	54,750	250	2	
3	5	Heat and Other Utilities	Bed Days Available	657,730	11	17,488	54,750	1,456	3	
4	6	Maintenance	Bed Days Available	657,730	11	8,697	54,750	724	4	
5	19	Professional Services	Bed Days Available	657,730	11	49,378	54,750	4,110	5	
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	657,730	11	1,616	54,750	135	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,730	11	485,405	432,056	54,750	40,406	7
8	24	Travel and Seminar	Bed Days Available	657,730	11	186	54,750	15	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,730	11	14,707	54,750	1,224	9	
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	657,730	11	5,991	54,750	499	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,730	11	182,974	54,750	15,231	11	
12	33	Real Estate Taxes	Bed Days Available	657,730	11	42,159	54,750	3,509	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,730	11	12,559	54,750	1,045	13	
14									14	
15									15	
16									16	
17	17	Administrative	Avg Hours Worked	40	11	382,400	382,400	3	28,680	17
18		Administrative	Avg Hours Worked	50	6	191,200	191,200	5	19,120	18
19									19	
20	30	Depreciation	Direct Cost						2,555	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,397,941	\$ 1,005,656	\$ 118,974	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S & E Medical Supply Co.
 Street Address 3100 Commercial Avenue
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 982-9300
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 8,002	1
2	3	Housekeeping	Direct Cost					320	2
3	10	Medical Supplies	Direct Cost					3,099	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 11,421	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/09 Ending: 12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Heartland Bank		X	Mortgage	\$23,524.00	11/27/01	\$ 3,961,000	\$ 3,641,265	12/1/36	0.0635	\$ 232,548	1								
2												2								
3							Amortization of Mortgage Costs				4,312	3								
4												4								
5												5								
Working Capital																				
6	N/P Stockholders	X		Working Capital				75,000			15,402	6								
7												7								
8												8								
9	TOTAL Facility Related				\$23,524.00		\$ 3,961,000	\$ 3,716,265			\$ 252,262	9								
B. Non-Facility Related*																				
10												10								
11							Related Party Interest Expense net of Interest Income				(4,037)	11								
12							Interest Income Offset				(11,211)	12								
13							Interest Income from Real Estate Entity				(154)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (15,402)	14								
15	TOTALS (line 9+line14)						\$ 3,961,000	\$ 3,716,265			\$ 236,860	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,321 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Rows include Resident Care, Office Space for Employees, and a TOTALS row.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	2001		\$ 2,928,441	\$	15-40	\$ 73,713	\$ 73,713	\$ 647,556	4
5		2006		55,818	2,030	40	1,431	(599)	5,009	5
6										6
7	Allocated from Management Co.	1995		36,031		39	1,029	1,029	15,086	7
8										8
Improvement Type**										
9	Various		1994	17,857	268	20	523	255	15,417	9
10	Various		1995	33,623	337	20	1,681	1,344	24,774	10
11	Various		1996	2,178	56	20	109	53	1,489	11
12	Various		1997	9,423		20	471	471	5,892	12
13	Various		1998	4,800	123	20	240	117	2,760	13
14	Various		1999	16,266	93	20	813	720	8,725	14
15	Air Handler		2000	1,516		5			1,516	15
16	Alarm System		2001	1,908		5			1,908	16
17	Blind		2001	1,212		5			1,212	17
18	Air Handler		2001	1,317		20	66	66	560	18
19	Fan Motor		2001	1,123		20	56	56	454	19
20	Drywall-Dining Room		2002	10,650	184	10	1,065	881	8,343	20
21	Door		2002	9,860	184	20	493	309	3,492	21
22	Air Conditioner		2002	1,198		7	71	71	1,198	22
23	Air Conditioner		2002	1,582		7	94	94	1,582	23
24	Air Conditioners		2002	4,284		7	306	306	4,284	24
25	Compressor Air Maxi		2002	1,269		7	60	60	1,269	25
26	Roof - New		2003	97,996	2,513	20	4,900	2,387	33,074	26
27	Nursing Station		2003	35,060		20	1,753	1,753	11,102	27
28	Nursing Station		2003	28,692		20	1,435	1,435	10,282	28
29	Nursing Station		2003	6,368		20	318	318	1,937	29
30	Replace Accelerator		2003	968		20	48	48	338	30
31	Sprinkler System		2004	3,610	131	20	181	50	993	31
32	Smoke shelter		2004	6,041	220	20	302	82	1,661	32
33	Security System		2005	11,166	406	20	558	152	2,512	33
34	Condensing Unit - 5 Ton		2005	1,959	71	20	98	27	441	34
35	Cabinets and countertops		2005	110,923	4,011	20	5,546	1,535	24,958	35
36	Air Handler		2005	1,549	56	20	78	22	349	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Asphalt Parking Lot	2005	\$ 5,570	\$ 386	20	\$ 279	\$ (108)	\$ 1,253	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	246	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	945	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	988	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	329	41
42	Door Alarms	2005	3,587	130	20	179	49	807	42
43	Wallpaper	2005	17,835		20	892	892	4,013	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	6,660	44
45	6 Doors	2005	1,926	70	20	96	26	433	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	2,338	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	1,098	47
48	Duct Heater	2006	1,195	43	20	60	17	209	48
49	Kitchen Garbage Disposal	2006	1,467	169	20	73	(96)	257	49
50	Copper Pipe & Concrete	2006	3,722	135	20	186	51	651	50
51	Fence	2006	6,061	467	20	303	(164)	1,061	51
52	Shower Remodel - Hall 400	2006	21,570	784	20	1,079	295	3,775	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	1,706	53
54	Shower Remodel - Hall 200	2006	21,570	784	20	1,079	295	3,775	54
55	Shower Remodel - Hall 500	2006	21,570	784	20	1,079	295	3,775	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	3,426	56
57	Front Entrance	2006	2,150	78	20	108	30	376	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	588	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	303	59
60	Compressor-Walk In Freezer	2006	1,784	65	20	89	24	312	60
61	Air Conditioners (5)	2006	2,146	247	10	215	(32)	751	61
62	Air Conditioners (6)	2006	2,576	297	20	129	(168)	451	62
63	Phone System	2006	1,658	191	20	83	(108)	290	63
64	Remove & reinstall 6 dry pendants	2007	3,039	111	20	152	41	380	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	938	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	158	43	395	66
67	New Window Glass	2007	3,562	130	20	178	48	445	67
68	Paving, Parking Lot & Driveway	2007	32,275	2,759	20	1,614	(1,145)	4,034	68
69	Handrails	2007	2,980		20	149	149	373	69
70	TOTAL (lines 4 thru 69)		\$ 3,704,025	\$ 20,754		\$ 110,513	\$ 89,759	\$ 887,553	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,704,025	\$ 20,754		\$ 110,513	\$ 89,759	\$ 887,553	1
2	Fire Damper and Roof Vent	2007	5,114	186	20	256	70	639	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790		20	440	440	1,099	3
4	Walk In Freezer Door	2007	2,316	84	20	116	32	290	4
5	Replace 4 Inch Main	2008	3,158	115	20	158	43	237	5
6	Sprinkler heads for alarm	2008	29,310	1,066	20	1,466	400	2,198	6
7	Sign	2008	2,685		20	134	134	201	7
8	Hot Water Heater	2009	5,182	118	20	130	12	130	8
9	Vinyl Flooring	2009	14,512	66	20	363	297	363	9
10	Hot Water Heater	2009	5,094	177	20	127	(50)	127	10
11									11
12	Depreciation to agree with financial statements			27,905			(27,905)		12
13									13
14									14
15									15
16	Allocated from SW Management - Leasehold Improvements	1995	3,844		20	192	192	3,088	16
17	Allocated from SW Management - Leasehold Improvements	1996	671		20	34	34	455	17
18	Allocated from SW Management - Leasehold Improvements	1997	967		20	48	48	724	18
19	Allocated from SW Management - Leasehold Improvements	1998	666		20	33	33	391	19
20	Allocated from SW Management - Leasehold Improvements	1999	1,848		20	92	92	932	20
21	Allocated from SW Management - Leasehold Improvements	2005	3,823		20	191	191	860	21
22	Allocated from SW Management - Leasehold Improvements	2007	2,164		20	108	108	271	22
23	Allocated from SW Management - Leasehold Improvements	2009	4,518		20	113	113	113	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,798,687	\$ 50,471		\$ 114,512	\$ 64,041	\$ 899,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 739,841	\$ 2,977	\$ 11,120	\$ 8,143	10	\$ 533,718	71
72	Current Year Purchases	69,764	41,859	3,489	(38,370)	10	3,489	72
73	Fully Depreciated Assets	135,946					135,946	73
74	Allocated from Management Co.	11,375		231	231	10	8,569	74
75	TOTALS	\$ 956,926	\$ 44,836	\$ 14,840	\$ (29,996)		\$ 681,722	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management	Cadillac	2004	\$ 4,825	\$	\$ 482	\$ 482	5	\$ 4,825	76
77										77
78										78
79										79
80	TOTALS			\$ 4,825	\$	\$ 482	\$ 482		\$ 4,825	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,005,438	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,307	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 129,834	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,527	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,586,218	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Management Co.</u>		\$	\$ <u>1,045</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,045</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,887	\$ 135,887	\$	1,887	\$ 135,887	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,533	73,563		1,533	73,563	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,112	135,188		2,112	135,188	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				111,048		111,048	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Veterans Expense</u>	L39, C2					66,261		66,261	12
13	Other (specify):									13
14	TOTAL			\$	5,532	\$ 344,638	\$ 177,309	5,532	\$ 521,947	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Cahokia Nursing & Rehabilitation Center**

0039636

Report Period Beginning: **01/01/09**

Ending: **12/31/09**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,000	\$ 1,000	1
2	Cash-Patient Deposits	35,277	35,277	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,000</u>)	990,983	990,983	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,292	17,285	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	313,228	623,353	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,356,780	\$ 1,667,898	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	3,020,289	14
15	Leasehold Improvements, at Historical Cost	622,867	778,398	15
16	Equipment, at Historical Cost	462,679	961,751	16
17	Accumulated Depreciation (book methods)	(631,738)	(1,586,218)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>See Schedule 17A</u>		116,628	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 524,626	\$ 3,535,848	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,881,406	\$ 5,203,746	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 396,089	\$ 357,754	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,480	42,480	28
29	Short-Term Notes Payable	75,000	75,000	29
30	Accrued Salaries Payable	73,143	73,143	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,759	8,759	31
32	Accrued Real Estate Taxes(Sch.IX-B)		151,000	32
33	Accrued Interest Payable		19,269	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	566,992	110,648	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,162,463	\$ 838,053	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		3,641,265	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,641,265	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,162,463	\$ 4,479,318	46
47	TOTAL EQUITY(page 18, line 24)	\$ 718,943	\$ 724,428	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,881,406	\$ 5,203,746	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Cahokia Nursing & Rehabilitation Center, Inc.
 Provider #: 0039636
 12/31/2009

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve	-	156,115
RE Escrow Real Estate Tax	-	154,010
Short Term Loan Exchange	313,228	313,228
Total Line 9-Other Current Assets (Specify)	313,228	623,353

Other Long-Term Assets (Specify)

RE Capitalized Costs	-	150,935
RE Accumulated Amortization	-	(34,307)
Total Line 22-Other Long-Term Assets (specify)	-	116,628

Other Current Liabilities (Specify)

Insurance Premiums Payable	(1,270)	(1,270)
Acc. Retirement (From P/R)	-	-
Accrued Expenses	(73,639)	(73,639)
Due to Public Aid	(1,086)	(1,086)
Due/From Cahokia Property LLC	(476,824)	(20,480)
Due/From Vacant Cahokia Property	(14,173)	(14,173)
Total Line 36-Other Current Liabilities (Specify)	(566,992)	(110,648)

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 427,637	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 427,637	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	291,309	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 291,306	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 718,943	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/09

Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,638,849	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,638,849	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	310,522	6
7	Oxygen	13,330	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 323,852	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,211	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,211	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,518	28
28a	Medicaid Income Adjustment	16,561	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,079	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,991,991	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,113,680	31
32	Health Care	2,372,826	32
33	General Administration	1,255,345	33
B. Capital Expense			
34	Ownership	670,709	34
C. Ancillary Expense			
35	Special Cost Centers	205,997	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,700,682	40
41	Income before Income Taxes (line 30 minus line 40)**	291,309	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 291,309	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Cahokia Nursing & Rehabilitation Center**

0039636

Report Period Beginning:

01/01/09

Ending:

12/31/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	2,080	\$ 64,464	\$ 30.99	1
2	Assistant Director of Nursing	1,480	1,520	42,308	27.83	2
3	Registered Nurses	2,928	3,189	97,378	30.54	3
4	Licensed Practical Nurses	25,276	26,842	556,835	20.74	4
5	CNAs & Orderlies	90,623	95,796	964,157	10.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,057	7,874	98,031	12.45	8
9	Activity Director					9
10	Activity Assistants	5,954	6,248	67,359	10.78	10
11	Social Service Workers	3,476	3,739	47,175	12.62	11
12	Dietician					12
13	Food Service Supervisor	1,615	1,960	29,204	14.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,688	21,323	198,085	9.29	15
16	Dishwashers					16
17	Maintenance Workers	3,505	3,763	45,427	12.07	17
18	Housekeepers	17,533	18,589	149,619	8.05	18
19	Laundry	10,419	11,042	95,533	8.65	19
20	Administrator	4,016	4,160	211,770	50.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,709	17,032	354,211	20.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,159	225,157	\$ 3,021,556 *	\$ 13.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 3,364	L1, C3	35
36	Medical Director	Monthly	3,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,797	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	6,236	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	120	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,767		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center, Inc.

Provider # : 0039636

12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	39,680
Adjust to client legal invoices	44
Allocated from Real Estate Entity - Legal	14,513
Allocated from Real Estate Entity - Accounting	7,625
Allocated from Mangement Company - Legal	2,603
Allocated from Mangement Company - Accounting	1,507
Total (Agree to Schedule V, Line 19, Column 8)	<u>65,972</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2006					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care-\$16,180
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,407 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,894 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT